Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEVE GAO, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-11-4248-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: From Table of Disputed Services: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED." From a letter dated May 27, 2011: "The attached claim has been amended to reflect some additional charges that were not included in original billing. At this time, I am requesting that this claim be reviewed once again, and placed in line for additional reimbursement."

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EES14 and the DWC32 does not ask the DD to address Extent of Injury or additional impairment ratings for non-compensable body areas therefore amending the bill and the report was not necessary. The Office however is disputing liability of medical and indemnity benefits for Left Knee, Degenerative Joint Disease of both knees, nervousness, anorexia and insomnia because these conditions are not related to the compensable injury which has been accepted as a only a right knee sprain. Thorough review of this dispute the Office found that the requestor failed to support or justify his request for additional reimbursement of $150.00 for CPT code 99456-W5-WP."

Response Submitted by: State Office of Risk Management, PO BOX 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2011	99456-W5-WP and 99080-73	$165.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated May 04, 2011
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCDURE

   Explanation of benefits dated June 09, 2011
   - 18 – DUPLICATE CLAIM/SERVICE
   - PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCDURE.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCDURE.
   - THE PROVIDER HAS SUBMITTED THIS BILL AS A RECONSIDERATION BUT HAS REMOVED/CHANGED THE DIAGNOSIS AND/OR CPT/HCPC CODE(s) AND/OR TOTAL BILLED AMOUNT. THUS MAKING IT A NEW BILL AND SUBJECT TO THE 95 DAY TIMELY FILING RULE.

   Explanation of benefits dated June 29, 2011
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCDURE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
   - DDE/MMI REACHED/IR@ROM OF ONE BODY AREA OF COMPENSABLE LOWER EXTREMITY-RT KNEE/RTW. PER RULE 134.202(e)(7); THE REIMBURSEMENT SHALL INCLUDE COMMISSION REQUIRED REPORTS. THE CARRIER DISPUTES PSYCH-FACTORS AND/OR NO REQUEST FROM CARRIER/COMMISSON FOR EXTENT OF INJURY/SIMILAR ISSUES/DISABILITY WAS TO BE ADDRESSED THEREFORE NO ADDITIONAL PAYMENT IS RECOMMENDED NOR MEDICALLY NECESSARY FOR AMENDED REPORT.
   - PREVIOUSLY PAYMENT OF SERVICES UNDER BILL ID#2397764

Issues

1. Has the requestor made a claim for additional body areas that have previously been deemed non-compensable when only compensable body areas were requested?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed for body areas billed for Impairment Rating (IR) that are not compensable. The respondent denied additional reimbursement using reason code "50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER". While this denial reason does not adequately explain the reason for denial, the bill note on the EOB dated June 29, 2011 explains fully the denial. The left knee and degenerative joint disease of the bilateral knees was disputed via PLN-11 on November 10, 2010. Insomnia, nervousness, and anorexia have been previously disputed via PLN-11 on December 1, 2010. The right knee, left knee, and insomnia are claimed as rated. However, only the right knee is compensable. The EES-14 and DWC32 did not ask the DD to address extent of injury issues or areas other than the right knee. Therefore, this review will proceed according to applicable fee guidelines in 28 Texas Administrative Code §134.204 and per narrative documentation of examinations.

2. The requestor originally submitted a bill for the DD examination Maximum Medical Improvement/Impairment Rating (MMI/IR) services for 1 body area/unit in box 24G of the CMS-1500 for $650.00 and billed with CPT code 99456-W5-WP. This amount was paid prior to MFDR. After this payment, the requestor amended the billing for CPT code 99456-W5-WP with an additional $150.00 and one more unit with a new total of $800.00. Review of the documentation supports that MMI was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Documentation supports a Range of Motion (ROM) IR method on the right knee (lower extremities) for a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The combined MAR for the MMI and IR is $650.00. The respondent has already reimbursed the amount of $650.00 for the disputed CPT code 99456-W5-WP. Regarding CPT code 99080-73, 28 Texas Administrative Code §134.204 states in part (k) that reimbursement "shall include Division-required reports." Therefore, no separate reimbursement is recommended.
3. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 13, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.